Report

to the

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services

On

Recommendations on the Death Reporting Requirements under North Carolina General Statute 122C-26(5)c

Session Law 2008-131
Senate Bill 1770
Section 3

December 2, 2008

North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services: Report on Death Reporting Requirements

December 2, 2008

Pursuant to Session Law 2008-131, Senate Bill 1770, the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services (Commission) is charged with studying the current death reporting requirements under N.C. Gen. Stat. 122C-26(5)c and assessing the need for any additional reporting requirements or modifications to existing rules or procedures.

The Commission, per the request from the North Carolina General Assembly, reviewed the process of death reporting from state-operated facilities and other mental health, developmental disabilities and substance abuse services facilities and heard several presentations from the North Carolina Department of Health and Human Services Divisions of Health Services Regulation and Mental Health, Developmental Disabilities and Substance Abuse Services. The Commission found the current reporting requirements for State-operated, licensed and unlicensed facilities to be unduly complex, with different timelines and reporting requirements depending on the type of death and whether the facility is State-operated, licensed or unlicensed (see attached reporting grids).

N.C. Gen. Stat. 122C-31 states that, *"A facility shall notify the Secretary immediately upon the death of any client of the facility that occurs within seven days of physical restraint or seclusion of the client, and shall notify the Secretary within three days of the death of any client of the facility resulting from violence, accident, suicide, or homicide."* However, *by policy* State-operated facilities (and not other facilities) must report *all deaths* regardless of cause. In addition, more recent legislation amended N.C. Gen. Stat. 122C-31 to require reporting in a licensed facility to the local Medical Examiner. See N.C. Gen. Stat. 122C-31(g).

The Commission's recommendations regarding all facilities are as follows:

- The Commission recognizes that the current reporting system has been developed and modified over time by statute, rule and policy.
- Wherever possible, these reporting requirements should be consistent and set forth in the North Carolina General Statutes.
- Statutes should also better reflect the diversity of the current facilities and programs serving mh/dd/sas clients.
- In addition, in smaller programs and services true independent internal review of deaths is not feasible at present. Independent review should be implemented.

The Commission's recommendations regarding State-operated facilities are listed below:

- For patients who die shortly after discharge, deaths may not be reported back to the facility, creating barriers to compliance. Ways to improve this linkage and reporting should be studied.
- For deaths occurring in State-operated facilities, any lapses in mandated death reporting should be regarded as a management problem for which the Directors of the facilities and their designees should be held strictly accountable.

Finally, the Commission recommends that the North Carolina General Assembly further study death reporting requirements and to the extent that is feasible:

- assure maximal consistency of reporting and review requirements across all types of facilities;
- assure independent review of deaths; and
- assure all State and LME reporting and reviewing responsibilities are clearly delineated and coordinated.

	State Operated[1]	Licensed	Unlicensed
Statutes	1. **NCGS 122C-31** – Any death in a State operated facility must be reported by the facility to the Medical Examiner in the county where the death occurs [cross reference 130A-383(a)] Additionally, a facility must notify the Secretary immediately upon death of any client of the facility that occurs within 7 days of physical restraint or seclusion, and within 3 days following death from violence, accident, suicide or homicide. (*Also applies to inpatient psychiatric hospitals licensed under NCGS 131E)	1. **NCGS 122C-31 -** A facility must notify the Secretary immediately upon death of any client of the facility that occurs within 7 days of physical restraint or seclusion, and within 3 days following death from violence, accident, suicide or homicide. (*Also applies to inpatient psychiatric hospitals licensed under NCGS 131E)[2]	
Rules	1. **10A NCAC 26C .0300 - .0303[3] –** Report deaths to DHSR which occur following restraint and seclusion, or from violence, accident, suicide or homicide.	1. **10 NCAC 26C .0300-.0303 -** Report deaths to DHSR which occur following restraint and seclusion, or from violence, accident, suicide or homicide. 2. **10 NCAC 27G .0604** – Must send copy of incident report for Level III incident (all deaths except natural deaths) to the LME and DMH within 72 hours of becoming aware of the incident. All Level II incidents (including natural deaths) must be reported to the LME directly, and the LME sends a report to DMH quarterly.	1. **10 NCAC 26C .301(b) –** Report deaths to DMH/DD/SAS 2. **10 NCAC 27G .0604** – Must send copy of incident report for Level III incident to Home and Host LME(s) and DMH within 72 hours of becoming aware of the incident.
Policies	1. **APSR 4092**- Approved March 26, 2008 – Facilities must report deaths of patients which occur at State operated facilities to the ME in the county in which the body of the deceased is located, to Division of Health Services Regulation, and the State Operated Services of the Division of MH/DD/SAS. If the death resulted while or within 24 hours of the patient being secluded or restrained, facility must report by the close of the next business day. All other deaths in facilities must be reported within 3 business days.		1. **September 20, 2007 Memo** - Effective Oct. 1, 2007, all consumer deaths from Unknown Causes are to be considered and processed as Level III incidents and reported to the home and host LME(s) and the Divisions Quality Management Team.

Created for exclusive use of The North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services. The sole intended use of this document is to assist the Commission in studying death reporting requirements pursuant to N.C. Gen. Stat. 122C-26(5)(c) and Session Law 2008-131. It is not intended as an exhaustive review of all death reporting statutes.

[1] State Operated Facilities are operated under Secretary Rules, pursuant to NCGS 122C-112.1(b)(10)
[2] Facilities, such as adult care homes and facilities for the care of minors are governed by statutory requirements, found in NCGS 131D-34.1 and 131D-10.6, respectively.
[3] .0301 states that licensed facilities shall report client deaths to the Division of Health Service Regulations and unlicensed facilities shall report client deaths to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. This death report is restricted in .0303(b) and (c) to deaths following restraint and seclusion, or from violence, accident, suicide or homicide.

	Type of Facility	State Operated Facilities[4]	Licensed Facilities (not state operated)	Unlicensed Facilities (Not State Operated)
	Agency in charge of monitoring/ triaging death reports	**DHSR, DMH/DD/SAS and State Operated Services**	**DHSR, LME, and DMH/DD/SAS (Quality Management Team and Customer Service)**	**Local Management Entities (Host) and DMH/DD/SAS**
TYPE OF DEATH	Restraint and Seclusion (report all deaths occurring within 7 days of restraint and seclusion)	Statute: 122C-31 Rule: 10A NCAC 26C .0300 *et seq.* Policy: APSR 4092 Procedure[5]: DHSR triages and immediately initiates investigation of deaths upon receipt of death report; sends report to Disability Rights of NC. Reviewed by the Medical Examiner.	Statute: 122C-31 Rule: 10A NCAC 26C .0300 *et seq.*;10A NCAC 27G .0604 Procedure: DHSR triages and immediately initiates investigation of deaths upon receipt of death report; sends report to Disability Rights of NC. If the consumer receives publicly funded mh/dd/sas, providers report to DHSR. Level III deaths reports are submitted to LMEs and DMH/DD/SAS. LME reviews to ensure that death was reported to DHSR.	Rule: 10 NCAC 27G .0604 Procedure: LME will review, triage, and provide monitoring as needed; DMH provides additional follow up as needed.
	Violence, accident, homicide, suicide (report within 3 days)	Statute: 122C-31 Rule: 10A NCAC 26C .0300 *et seq.* Policy: APSR 4092 (details reporting procedures to CMS, DHSR, State Operated Services, and the Medical Examiner.) Procedure: DHSR triages and investigates deaths as needed; sends report to Disability Rights of NC. Reviewed by the Medical Examiner.	Statute: 122C-31 Rule: 10A NCAC 26C .0300 *et seq.*; 10A NCAC 27G .0604 Procedure: DHSR triages and investigates deaths as needed; sends report to Disability Rights of NC. If the consumer receives publicly funded mh/dd/sas, providers report to DHSR. Level III deaths reports are submitted to LMEs and DMH/DD/SAS. LME reviews to ensure that death was reported to DHSR..	Rule: 10 NCAC 27G .0604 Procedure: LME will review, triage, and provide monitoring as needed; DMH provides additional follow up as needed.
	Unknown	Policy: ASPR 4092 Procedure: Investigation as determined by DHSR and Medical Examiner.	Rule: 10A NCAC 27G .0604 Policy: Sept. 20, 2007 Memo Procedure: LME must report the death to Quality Management of DMH of DMH/DD/SAS. LME will review, triage, and provide monitoring; DMH provides additional follow up as needed.	Rule: 10A NCAC 27G .0604 Policy: Sept. 20, 2007 Memo (all deaths from unknown causes are processed as Level III incidents) Procedure: LME will review, triage, and provide monitoring as needed; DMH provides additional follow up as needed.
	Natural Causes	Policy: APSR 4092 Procedure: Investigation as determined by DHSR and Medical Examiner.	Rule: 10 NCAC 27G .0604 (Level II incidents are reported the LME, which must report to DMH all Level II incidents quarterly) Procedure: LME will triage, and provide monitoring as needed.	Rule: 10 NCAC 27G .0604 Procedure: LME will review, triage, and provide monitoring as needed; DMH provides additional follow up as needed.

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[4] State Operated Facilities are operated under Secretary Rules, pursuant to NCGS 122C-112.1(b)(10).
[5] These procedures refer to the process various agencies follow after receiving a report of a death.